STATE OF IDAHO

Group Insurance Administration Manual

2002

GROUP INSURANCE ADMINISTRATION MANUAL

The Office of Insurance Management, Department of Administration as established in Idaho Code 67, Chapter 57, sponsors and is responsible for the administration of all group life, accidental death and dismemberment, disability, medical, dental, integrated behavioral health and flexible spending account programs, insurance contracts and policies for the employees of the State of Idaho and their dependents.

The Office of Insurance Management is pleased to provide this Group Insurance Administration Manual to all State agencies. It is designed to serve as a guide to your role in helping us administer the various group insurance plans.

HOW THIS MANUAL WORKS

This Administration Manual is organized by event, that is, according to a variety of circumstances under which employees may enroll for benefits or make election changes. For each event, the manual includes...

- rules that apply to employee elections,
- your role, which includes verifying eligibility, making sure employees enroll accurately and on time, and completing the premium payment procedure
- Frequently Asked Questions, answers to questions about how benefit rules and administrative procedures work in real life.

On page 50 of this manual, you'll also find an Exhibits section with samples of various enrollment, claim and administrative forms.

OTHER RESOURCES

The Group Insurance Administration Manual is designed to be used in conjunction with:

- ***Employee Group Insurance Handbook*** summarizes group insurance benefits available to eligible employees and their dependents. It also includes employee premiums for the current plan year as well as addresses, phone numbers and websites for contacting representatives for the various plans as well as the individual contracts for each plan. The handbook is available online at the Department of Administration, Office of Insurance Management website at www2.state.id.us/adm/insurance/default.htm

- ***Employee Information System (EIS) Manual*** from the Controller's Office applies to all agencies on biweekly payroll. Among other information, the EIS Manual includes detailed instructions for reporting and paying premiums on behalf of eligible participants.
- ***Office of Insurance Management*** is available to answer any questions the agencies or employees may have about group insurance or the administration of the plans. In addition, the Office of Insurance Management is your resource for all benefit material, including enrollment and other forms. We also deal directly with employees on such issues as continuation of benefits during COBRA, Disability Plan claims, appeal of denied claims, and enrollment for retiree medical benefits.

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I. GROUP INSURANCE PLANS AT A GLANCE

Here in brief are the State of Idaho employee group insurance plans discussed in this Group Insurance Administration Manual. For more information about plan benefits and provisions, refer to the Employee Group Insurance Handbook available on the Department of Administration website.

Plans	Description of Coverage	How Monthly Premiums Are Paid
Premium Only Plan	Employees who elect this plan can pay medical and dental premiums on a before-tax basis	Employee share of premiums is deducted before federal or state income or FICA taxes are withheld
Medical	Current options are: • Regence Blue Shield of Idaho Plans, Module 1 and Module 2 • HMOBlue Northern Idaho Point of Service (POS) Plan, available only to employees who live in plan service area • Decline coverage	Agencies and employees share the cost
Integrated Behavioral Health Program (IBHP)	Includes: • Mental Health and Substance Abuse Benefits, available only to participants enrolled for a State employee medical plan • EAP Benefits, available to all benefit-eligible employees and dependents	Cost included in medical plan employer premium
Dental	Delta Dental, automatic for all participants enrolled in a medical plan (employees may decline coverage for enrolled dependents)	Agencies and employees share the cost
Basic Life/Dep Life Insurance	Automatic coverage for eligible employees equal to 1 times annual salary, eligible dependents are also covered	Agencies pay full cost
Disability Program	Automatic coverage for eligible employees, includes: • Short Term Disability • Long Term Disability	Agencies pay full cost as part of Basic Life premium
Supplemental Life Insurance	Employees may purchase additional coverage equal to 1 times annual salary	Employees pay full cost
State Police Optional Life	$50,000 coverage, available for eligible employees of the Idaho State Police	Employees pay 50% of cost, agencies pay 50%
Flexible Spending Accounts (FSAs)	Eligible employees can use either or both accounts to pay eligible expenses on a before-tax basis: • Dependent Care FSA • Health Care FSA	Employees make all FSA contributions

II. INSURANCE ADMINISTRATION IN GENERAL

ELIGIBILITY RULES

NOTE: Temporary or part-time employees hired by your agency may be eligible for benefits if they are also working for another State agency. You'll need to coordinate with the other agency to determine eligibility status of these employees.

1. ELIGIBLE EMPLOYEES

A. In order to be eligible for group insurance coverages, an employee must be:

- an officer or an employee of a state department, agency or institution, working 20 or more hours per week and
- whose term of employment is expected to exceed five months in any consecutive 12 month period.

Board and commission members must also work 20 hours per week, for at least five months in any consecutive 12-month period to be eligible for group insurance benefits.

Any employee scheduled to work 84 hours per month and expected to work at least five months during any consecutive 12-month period shall be deemed to meet the 20-hour per week requirement. These employees receive coverage only when they meet the eligibility requirements. Hours worked in any given month are used to determine the following month's eligibility for benefits.

NOTE: In order for an employee to enroll for dental coverage, he or she must be a member of one of the State's medical plans.

B. Medical Point of Service (POS) Plan Eligibility. Employees enrolling in the HMOBlue Plan must reside in the plan's service area. Service areas are outlined in the Employee Group Insurance Handbook.

2. ELIGIBLE DEPENDENTS

A. Life Insurance. Eligible dependents are the employee's legal spouse, and each of the employee's unmarried children including:

- Stepchildren, legally adopted children and children under a court appointed guardianship who rely on the employee for principal support and maintenance and who are at least 10 days but less than 19 years of age.
- Unmarried children between the ages of 19 and 23 who are eligible to be claimed by the employee as dependents for federal income tax purposes will continue to be covered.

- An unmarried child insured under the plan prior to the terminating age who is incapable of self-sustaining employment by reason of Developmental Disability or Physical Handicap and who becomes so incapacitated prior to the terminating age, and is chiefly dependent up the employee for support and maintenance, will not terminate while the insurance of the employee remains in force and the Dependent remains in such condition, if the employee has, within 31 days of such Dependent's attainment of the termination age, submitted proof of such Dependent's incapacity and dependency, and submits such proof subsequently as may be required by the insurer, but not more frequently than annually after the Dependent's attainment of age 23.

B. Medical, IBHP and Dental Coverage. Dependent means:

- The legal spouse of the enrolled employee and/or
- The unmarried child of an enrolled employee or enrolled employee's spouse, up to his or her 19th birthday. The term "children" includes natural children, step-children, adopted children, or children in the process of adoption from the time placed with the enrolled employee. The term "children" also includes children legally dependent upon the enrolled employee or enrolled employee's spouse for support where a normal parent-child relationship exists with the expectation that the enrolled employee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the enrolled employee, a parent-child relationship shall not be deemed to exist, even though the enrolled employee or the enrolled employee's spouse provides support.

  Such child may be covered beyond his or her 19th birthday, but not beyond the end of the calendar month in which the child attains the age of 23, so long as the child remains unmarried and is eligible to be claimed as a dependent on the enrolled employee's most recent U.S. Individual Income Tax Return.

  Any unmarried child currently enrolled in the group who is or becomes incapable of self-sustaining employment by reason of developmental disability or physical handicap prior to reaching the age of 23 and who is primarily dependent upon the enrolled employee for support and maintenance, shall not be terminated while the policy remains in force and the dependent remains in such condition if the enrolled employee has within 30 days of such dependent's reaching the age 23 submitted proof of such dependent's incapacity as herein described. The carrier may require subsequent proof of the dependent's disability and dependency, but not more frequently than once each year.

NOTE: In order for an employee or dependent to be eligible for dental coverage, he or she must be a member of one of the State's medical plans. All enrolled dependents in a family have the same medical or medical and dental benefits.

C. POS Plan Eligibility. Dependents enrolling in the HMOBlue Plan must also reside in the plan's service area. Certain exceptions are allowed for dependents temporarily residing outside the service area or those who must be allowed coverage due to a Qualified Medical Child Support Order. Please refer the employee to the Group Insurance Handbook and the POS plan member handbook, which HMOBlue mails to employees along with their ID cards, for further details.

PAYING PREMIUMS

1. IF YOUR AGENCY IS ON BI-WEEKLY PAYROLL

The Employee Information System (EIS) is the State's payroll system within the State Controller's Office. The Controller's Office Division of Statewide Payroll provides an EIS Manual, in which you'll find detailed procedures for paying premiums under the biweekly payroll system. Keep in mind, since procedures can change from time to time, to be sure to follow the most recent procedures outlined in your EIS manual.

In general, your role in the premium payment process is to...

- Complete the appropriate EIS set-up form for each newly enrolled employee. You'll need to enter all information requested on the forms including current codes for deductions and family coverage, if applicable. You can find the current codes in the EIS Manual.
- Make necessary manual adjustments to initial premiums. You may have to make manual adjustments for the employee's first month of coverage. The EIS Manual spells out in detail how to make these adjustments.
- Calculate Supplemental Life premiums. Each employee who elects this coverage pays the full premium — the cost depends on that person's age and benefit amount. You calculate the monthly premium as shown below.
- **NOTE:** employees who apply for Supplemental Life after the 60-day initial enrollment period must provide Evidence of Insurability. Before you begin premium deductions, wait until the Office of Insurance Management notifies you that the employee's application has been accepted.
- Submit the EIS set-up form promptly to the Controller's Office.
- Audit payroll deduction reports from the Controller's Office, to verify all necessary premium payments and adjustments for your agency have been made.
- Revise information as instructed in the EIS manual. This may be necessary, for instance, when employees make changes that affect premiums, such as adding or dropping coverage for themselves or dependents, going on leave, or terminating employment.

Calculating Supplemental Life Premiums — Bi-Weekly Payroll

1. Determine the employee's annual salary. Annual salary for...
   - Full-time employees = hourly rate of pay x 2080
   - Part-time employees = hourly rate of pay x 2080 x FTE
2. Determine the employee's coverage. For most employees, this equals annual salary, rounded up to the next higher $1,000, unless already an even multiple of $1,000. For Legislators, the limit is $10,000.
3. Based on the individual's coverage and age bracket, calculate the monthly cost using current premium rates.
4. After initial enrollment, you'll need to adjust premium amounts when the employee's salary changes. Since the coverage amount is based on annual salary, a change in pay may affect the monthly cost.

2. IF YOUR AGENCY IS ON MONTHLY PAYROLL

Your agency is responsible for sending the Office of Insurance Management monthly premiums on behalf of all eligible enrolled employees. Briefly, here's how:

A. Medical (includes IBHP premium) and Dental premiums. To add employees and their dependents to a medical or dental plan, on the monthly billing statement...

- Write in the employee's name, Social Security, and premium amount on the appropriate statement.
- Recalculate the new total premium amount due.
- Send the Office of Insurance Management the corrected billing statement along with the total premium due for the plan by the fifth of the month.

B. Basic Life Premium. On the monthly Premium Reconciliation form...

- Calculate your agency's monthly premium for eligible active employees, including any new employees. To do this...
  - ✦ In the appropriate sections, enter the total number of eligible active employees and the prior month's certified payroll for eligible employees.
  - ✦ Multiply the certified payroll by the premium rate as listed on the Reconciliation form. Although all employees have a minimum of $20,000 worth of basic life insurance coverage, the monthly premium is based on the actual monthly salary.
  - ✦ Explain all premium adjustments by entering the name of the employee, amount of adjustment, month to which the adjustment applies, and why the adjustment is necessary.

- Sign the completed form and send it with your agency's premium payment to the Office of Insurance Management by the fifth of each month.

PLEASE NOTE: If an employee is working in more than one position and has enough hours to meet the eligibility requirements, your agency must pay life insurance premiums on all positions.

C. Supplemental Life Premiums. Employees who elect Supplemental Life pay the full cost of the premiums through payroll deduction. As shown below, you calculate employee premiums based on each person's age and coverage amount.

1. Complete the Supplemental Life Insurance Premium Reconciliation form, on which you indicate premiums due, including any additional premiums for new employees.
2. Send in the total premiums along with the Reconciliation form to the Office of Insurance Management by the fifth of each month.
3. Adjust premium amounts when...
   - The employee's salary changes. Since the coverage amount is based on annual salary, a change in pay may affect the monthly cost.
   - The employee has a birthday that moves him or her into a higher premium bracket. These adjustments are made once a year, effective July 1.

NOTE: Employees who apply for Supplemental Life after the 60-day initial enrollment period must provide Evidence of Insurability. Before you include premium payment information about these employees on your report, wait until the Office of Insurance Management notifies you that the employee's application has been approved.

Calculating Supplemental Life Premiums — Monthly Payroll

1. Determine the employee's annual salary. Annual salary for...
   - Full-time employees = monthly salary x 12.
   - Part-time employees = monthly salary x 12 times the actual full-time equivalent hours worked, times the actual full-time equivalent months worked.
2. Determine the employee's coverage. Employees may purchase insurance equal to annual salary, rounded to the next higher $1,000, if not already a multiple of $1,000.
3. Calculate the monthly cost, based on the individual's coverage and age bracket using current rates shown in the Employee Group Insurance Handbook.

III. EVENTS

A. WHEN AN EMPLOYEE IS NEW.

B. WHEN AN EMPLOYEE MAKES CHANGES.

C. WHEN AN EMPLOYEE GOES ON LEAVE.

D. WHEN AN EMPLOYEE RETURNS FROM LEAVE.

E. WHEN AN EMPLOYEE TRANSFERS AGENCIES.

F. WHEN AN EMPLOYEE FILES A CLAIM FOR BENEFITS.

G. WHEN A PARTICIPANT LOSES ELIGIBILITY.

H. WHEN A PARTICIPANT CONTINUES COVERAGE AFTER LOSS OF ELIGIBILITY.

A. WHEN AN EMPLOYEE IS NEW

✦ *Enrolling New Employees*

For samples of various forms discussed in this section, refer to Section V. Exhibits, page 50.

1. Premium Only Plan
2. Medical, Integrated Behavioral Heath Program (IBHP) and Dental
3. Basic Life
4. Disability Benefits
5. Supplemental Life Insurance
6. State Police Optional Life
7. Flexible Spending Accounts (FSAs)

New employees enroll for the coverage of their choice when they first come to work at your agency. The rules for enrollment differ from plan to plan.

After initial enrollment, employees may make changes only as described in Section B, *When An Employee May Change Benefits*, page 18.

RULES FOR ENROLLING NEW EMPLOYEES

1. Premium Only Plan

- All employees must elect or decline participation and submit the Premium Only Plan Election form to you within 60 days after they start work.
- For employees who elect to participate, before-tax premiums will be withheld starting with their first paycheck contributions.
- Elections employees make during initial enrollment apply through the end of that plan year. A plan year runs from July 1 through June 30.

2. Medical, Integrated Behavioral Health Plan (IBHP) and Dental

- To enroll themselves and their eligible dependents for medical, employees must complete and submit the appropriate enrollment form to you:
  - ✦ Regence Blue Shield of Idaho Enrollment form, to enroll for either Module 1 or Module 2
  - ✦ HMOBlue enrollment form, to enroll for the Point of Service (POS) plan

- To decline medical plan participation, employees must complete the declination of coverage portion of a medical enrollment form and submit it to you.
- Employees who enroll for medical automatically enroll for IBHP and dental coverages.
- Coverage for employees and dependents begins ...
  - ♦ the first day of the month following 90 days of employment, provided the enrollment form is completed within 60 days of hire.
  - ♦ the first of the month after the enrollment form is signed, if the form is not completed within the initial 60 day eligibility period.
- Employees are required to take dental coverage but they may decline dental for their enrolled dependents. To do that, they must submit a Dependent Dental Declination form to you. Unless the State holds a special dental open enrollment period, employees who submit a declination form will not be able to obtain dependent dental in the future.

3. Basic Life Insurance

- The first day of the month following 90 days of employment. If dependents are hospitalized on the day coverage is scheduled to begin, their coverage will start when they're released.
- Employees must complete and submit a State of Idaho Beneficiary Designation form GP 39859-5 to you within 60 days of their hire dates.

4. Disability Coverage

- Short Term Disability (STD) and Long Term Disability (LTD) coverages are automatically provided to eligible employees as part of the Basic Life Insurance plan.
- Coverage is effective on the same date as the Basic Life Insurance. For an employee who is not on active status that day, coverage begins when the employee returns to work.

5. Supplemental Life Insurance

- Employees can apply for or drop Supplemental Life coverage anytime — but all new employees must elect or decline coverage by selecting the appropriate box on the State of Idaho Beneficiary Designation form GP 39859-5.
- For employees who enroll within the first 60 days after their hire dates, coverage is effective the first day of the month following 90 days of employment.
- Those who apply for coverage after the 60-day initial enrollment period or after they've previously dropped coverage are late enrollees.
  - ♦ In addition to the beneficiary designation form, late enrollees have to provide proof of good health by submitting the Health Statement for Group Benefit Program form.

- ♦ Coverage is effective the first day of the month after the application has been approved.
- ♦ The Office of Insurance Management will notify your agency when the employee's application is accepted or rejected.

6. State Police Optional Life

- Employees must submit a State Police Life Beneficiary Designation form GP 41677 to you within 60 days after date of hire.
- Coverage is effective on the first day of the month following 90 days of employment.
- Those who apply for coverage after the 60-day initial enrollment period or after they've previously dropped coverage are late enrollees.
  - ♦ In addition to the election form, late enrollees have to provide proof of good health by submitting the Health Statement for Group Benefit Program form.
  - ♦ Coverage is effective the first day of the month after the application has been approved.
  - ♦ The Office of Insurance Management will notify your agency when the employee's application is accepted or rejected.

7. Flexible Spending Accounts (FSAs)

- The FSAs are not available to new employees.
- Eligible employees may elect to participate only during the annual open enrollment period.

YOUR ROLE

1. **Provide employees with the Employee Group Insurance Handbook.** If employees have Internet access, refer them to the State website, www2.state.id.us/adm/insurance/default.htm — indicate on your new employee orientation checklist that they have been given Internet access. If employees do not have Internet access, provide a printed copy of the handbook plus all recent Renewal Guides.
2. **Provide employees with enrollment and other applicable forms.** The Office of Insurance Management provides each agency with a supply of forms. For additional forms, contact us. For samples of various forms discussed in this section, refer to Exhibits, page 50.
3. **Collect and review enrollment forms.** Review submitted forms to be sure they're complete and have been signed by the employee.
   - Fill in any information from your agency as requested on the form.
   - For late enrollees in the Supplemental Life or State Police Life Insurance plans, make sure they submit a Statement For Group Benefit Program along with their election forms. The employee completes sections B. C. and D. Your agency completes section A.
   - Verify employee eligibility for benefits as outlined on page 7.

4. **Submit and file forms.** The procedure is different for each kind of enrollment form:
    - For Premium Only Plan, file the designated copy of the form in the employee's personnel file.
    - For Medical, file the designated copy of the plan enrollment form in the employee's personnel file. If applicable, include Dependent Dental Declination Form. Send the remaining copies of all submitted forms to the Office of Insurance Management.
    - For Basic and Supplemental Life, file the Beneficiary Designation form in the employee's personnel file.
    - For State Police Optional Life, file the enrollment forms in the employee's personnel file.
5. **Review reports and adjust premiums.**
    - If your agency is on bi-weekly payroll, follow the procedure described in the Employee Information System (EIS) manual.
    - If your agency is on monthly payroll, review the Billing Statements for the month in which the changes become effective. Write in the new information and recalculate the premium due. For details, see page 10.

FREQUENTLY ASKED QUESTIONS

1. What happens if a new employee fails to submit any enrollment forms?

That employee is assumed to have declined all elective coverage.

2. Do we have to do anything special to enroll employees and dependents for Dental or the Integrated Behavioral Health Program (IBHP)?

No, simply send in the designated copies of the completed medical plan forms to the Office of Insurance Management. We'll forward the forms to all the insurers, including the elected medical plan, Delta Dental and Business Psychology Associates, the IBHP insurer.

3. If employees have declined medical for themselves or dependents, how are they enrolled for Employee Assistance Program (EAP) services?

EAP services are available to all benefit-eligible employees and dependents, no enrollment necessary. When a participant first calls Business Psychology Associates to pre-approve EAP services, the Office of Insurance Management is contacted to verify eligibility.

4. Do we have to verify dependent eligibility for benefits?

While agencies are required to verify employee's eligibility, you are not required to verify dependents' eligibility for enrollment.

5. *If an employee submits a Dependent Dental Declination form, but later acquires a new dependent, is the new dependent eligible for dental coverage?*

Once an employee declines dependent dental, coverage is declined for all dependents present and future. This new dependent may only be enrolled for dental when and if the State holds a special Dental open enrollment.

6. *If an employee enrolls for Medical but doesn't enroll his or her children for coverage, does that mean the employee has also elected to decline dependent Dental?*

In the case of this employee, if he or she later enrolls dependents for Medical they're still eligible for Dental coverage. Only an employee who enrolls dependents for medical coverage but submits a Dependent Dental Declination form is considered to have declined dependent dental.

7. *For employees who participate in the Premium Only Plan, how do I make sure their premiums are deducted before-tax?*

If your agency is on a bi-weekly payroll, enter the pre- and post-tax deduction codes provided in the Controller's Office EIS manual. If your agency is on monthly payroll, take the appropriate action specified by your payroll deduction process.

8. *How are new employees enrolled for Basic Life and Disability Insurance, since there are no enrollment forms?*

Enrollment happens automatically but premium deductions do not. If your agency is on biweekly payroll, you must submit the appropriate payroll deduction setup form(s) to the Controller's Office. For agencies on monthly payroll, you must revise your agency's Basic Life Premium Reconciliation form.

9. *Following initial enrollment, is there a deadline for sending the new election forms to the Office of Insurance Management?*

While there's no official deadline, agencies should submit the applicable forms as promptly as possible to be sure that coverage begins on schedule.

10. *Why would an employee submit a Beneficiary Designation With UTMA (Uniform Transfer to Minors Act) Custodian form instead of just a Beneficiary Designation form?*

The Beneficiary Designations with UTMA Custodian form applies only to those who designate minors as their beneficiaries.

B. WHEN AN EMPLOYEE MAKES CHANGES

✦ *Changing Benefit Elections*

For samples of various forms discussed in this section, refer to Section V. Exhibits, page 50.

1. Annual open enrollment changes, switching medical plans, adding or dropping Premium Only Plan and electing Flexible Spending Accounts (FSAs)
2. Enrolling newly acquired dependents, for health care plans and Basic Life
3. Mid-year health care changes, enrolling late for coverage, declining medical, declining dependent dental, switching out of the Point of Service (POS) plan
4. Mid-year Flexible Spending Account (FSA) changes, increasing contributions
5. Supplemental Life changes, adding or dropping coverage
6. Beneficiary Changes
7. Name changes

Employees can change their current benefit elections for a variety of reasons. The rules for making those changes depend on the situation.

RULES FOR CHANGING BENEFIT ELECTIONS

1. Annual Open Enrollment Changes

Annual open enrollment is the only time that employees may switch medical plans, change their Premium Only Plan elections or enroll in the FSAs. Open enrollment is usually held in late April or early May. Benefit changes made at this time apply for the entire plan year, from July 1 through June 30.

Each year, the Office of Insurance Management sends all agencies instructions in advance of the upcoming annual open enrollment. We include such details as the exact dates of the open enrollment period and employee deadlines for submitting enrollment forms. We also provide information for employees about available benefit options, upcoming changes, and how to enroll for the benefits of their choice.

To make changes during annual open enrollment, employees must submit applicable election forms to you by the end of the open enrollment period.

- To switch medical plans, employees submit the appropriate enrollment form for their new plan — either the Regence BlueShield of Idaho election form (for Module 1 or Module 2) or HMOBlue election form.

- To add or drop Premium Only Plan participation employees submit a new Premium Only Plan Election form.
- To elect either or both FSAs, employees submit a Flexible Spending Account Election Form for the upcoming year. To be eligible to enroll, employees must have 10 months of continuous state service as of a July 1 plan year start date and be enrolled in a State medical plan.

2. Enrolling Newly Acquired Dependents

After acquiring new dependents through marriage, birth or adoption, an employee may enroll them at anytime for State Medical, Integrated Behavioral Health Program (IBHP) and Dental benefits (unless a Dependent Dental Declination is currently in effect).

- To enroll new dependents for Medical, Dental and IBHP, an employee must submit a revised enrollment form for his or her current medical plan, including the names and any other required information about existing and new dependents.
- For most newly acquired dependents enrolled within 60 days, coverage starts the first of the month after they become eligible.
- Coverage for newborn natural or adoptive children enrolled within 60 days after birth or placement is effective the date of birth.
- Eligible new dependents are automatically covered by Basic Life. Their coverage begins immediately, unless they're hospitalized on the date coverage is supposed to begin. In that case, coverage is delayed until their release.

3. Mid-Year Health Care Coverage Changes

A. Enrolling late for coverage. Eligible employees can enroll themselves or dependents for medical plan coverage anytime. When they enroll for Medical, they automatically elect IBHP and Dental coverage. Those who enroll for Medical after the 60-day initial eligibility period or after they have previously dropped coverage are considered late enrollees.

- To enroll late for coverage, employees submit an enrollment form for the medical plan of their choice.
- For those enrolled for Medical coverage, IBHP and Dental coverage is automatic.
- Coverage begins the first day of the month following the date their enrollment forms are completed.

B. Dropping medical coverage. A currently enrolled employee can drop medical coverage at any time by submitting a new enrollment form for his or her current plan.

- To drop coverage, the employee completes the declination of coverage section of the form. Since dependents can only be covered if the employee is enrolled, their coverage will end, too.

- To drop coverage for specific dependents, the employee lists just the family members who will remain covered.
- Employee coverage continues through the last day of the month in which the employee signs the revised medical plan enrollment form. Dependent coverage continues through the last day of the month in which the dependent loses eligibility or the employee signs the revised enrollment form, whichever occurs first.
- Employees who decline Medical automatically decline Dental coverage. Also, while they will continue to be eligible for the Employee Assistance Program, employees who decline Medical will not be eligible for Mental Health and Substance Abuse Treatment benefits under the IBHP.

C. Declining dependent Dental. Although employees are required to take Dental coverage, they can drop dental coverage for currently enrolled family members at any time.

- To decline dependent dental, employees submit a Dependent Dental Declination form.
- Coverage continues through the last day of the month in which the dependent loses eligibility or the employee signs the Dental Declination form, whichever occurs first.
- Once dependent dental coverage has been declined, family members can only be re-enrolled when and if the State holds a special Dental open enrollment.

D. Switching medical plans mid-year. Annual open enrollment is the only time employees may switch to a different medical plan option. An exception applies to employees enrolled in the HMOBlue Point of Service (POS) Plan.

- These employees may change to another available medical option only if they move outside the plan's service area.
- To switch to another plan, employees must submit an enrollment form for the new plan within 30 days after they move.
- Coverage under the new plan is effective the first day of the month after the date of application.

4. Mid-Year FSA Changes

If an employee elects to participate in an FSA, he or she may only increase contributions before the next annual open enrollment. No other mid-year changes are allowed.

- Changes are allowed only if the employee has experienced an appropriate change in family status.
- To increase contributions, the employee submits a revised FSA Election form indicating the new contribution amount.

- The Office of Insurance Management must review and approve any mid-year increases in FSA contributions. We'll notify your agency if the change has been approved.

5. Supplemental Life Changes

Employees can apply for or drop Supplemental Life coverage anytime. Those who elect coverage after the 60-day initial enrollment period or after they've previously dropped coverage are late enrollees.

- To add coverage, employees submit the State of Idaho Beneficiary Designation form GP 39859-5.
    - ✦ Late enrollees also have to provide proof of good health by submitting the Statement For Group Benefit Program along with their beneficiary designation forms.
    - ✦ Coverage is effective the first day of the month after the application has been approved.
    - ✦ The Office of Insurance Management will notify your agency when a determination regarding the employee's application has been made.
- To drop coverage, employees complete new beneficiary designation forms on which they've filled in the declination of coverage section.

6. Beneficiary Changes

Employees may change their beneficiaries for Basic Life, Supplemental or Police Optional Life Insurance at any time.

- To change Basic or Supplemental Life beneficiaries, employees must submit a new Beneficiary Designation form or, if applicable, Beneficiary Designation With UTMA Custodian form.
- To change State Police Life beneficiaries, employees complete a new beneficiary designation form GP 41677.
- Married employees need written approval from their spouses to name someone other than their spouses as beneficiaries.

7. Name Changes

- An employee who changes his or her name due to marriage or for any other reason should submit a revised enrollment form for each plan in which he or she is enrolled.

YOUR ROLE

1. Provide employees with enrollment and other applicable forms. The Office of Insurance Management provides each agency with a supply of forms. For additional forms, contact us. For samples of various forms discussed in this section, refer to Exhibits, page 50.

2. Collect and review enrollment forms. Review the submitted forms to be sure they're complete and have been signed by the employee.

   - Fill in any information from your agency as specified on the enrollment form.
   - For late enrollees in the Supplemental Life Insurance plan, make sure they submit a Statement For Group Benefit Program along with their beneficiary designation forms. The employee completes sections B. C. and D. Your agency completes section A.
   - Verify employee eligibility for benefits as outlined on page 6. For those who elect an FSA during open enrollment, verify they will have completed 10 months of service by July 1.

3. Submit and file forms. The procedure is different for each kind of enrollment form:

   - For Premium Only Plan and FSA, file the designated copy of the enrollment forms in the employee's personnel file.
   - For Medical, file the designated copy of each election form in the employee's personnel file. If applicable, include Dependent Dental Declination forms. Send remaining copies of all submitted election forms, including any Dependent Dental Declination form, to the Office of Insurance Management.
   - For Basic Life, Supplemental and State Police Optional Life, file the Beneficiary Designation form in the employee's personnel file.

4. Review reports and adjust premiums.

   - If your agency is on bi-weekly payroll, follow the procedure described in the Employee Information System (EIS) manual.
   - If your agency is on monthly payroll, review the Billing Statements for the month in which the changes become effective. Cross out any outdated information, write in the new information and recalculate the premium due. For details, see page 11.

NOTE: Keep in mind, all FSA deductions take place on pay dates in the plan year, and are not taken in advance like medical and dental premiums.

FREQUENTLY ASKED QUESTIONS

1. *During open enrollment, do employees have to return new enrollment forms if they want to continue benefit elections "as is" for the coming plan year?*

That depends on the plan:

- For the FSAs, employees must submit new election forms to participate each year.
- For the Premium Only Plan, no new forms are required.
- For the Medical plans, new enrollment forms are required only if employees are switching to a new plan.

2. *Do employees have to complete a new election form to switch from one Regence BlueShield of Idaho module to another during annual open enrollment?*

Yes. To switch to a different module, an employee must complete a Regence BlueShield of Idaho Medical Plan Enrollment form on which he or she indicates the new plan.

3. *If employees are enrolled in the HMOBlue Point of Service (POS) medical plan, can they switch to another plan if their covered dependents move out of the POS service area?*

No, employees may only switch plans during annual open enrollment or if they move out of the plan service area. However, the POS plan has special coverage provisions for enrolled children who move away, for example, due to divorce or because they're going to school. For more information, refer the employee to his/her HMOBlue Member Handbook or the Employee Group Insurance Handbook.

4. *How are newly acquired dependents enrolled for Dependent Life?*

There's no special procedure to enroll dependents for this coverage. If the employee ever makes a claim for dependent benefits, then we will verify that the dependent was eligible.

C. WHEN AN EMPLOYEE GOES ON LEAVE

✦ *Continuing Benefits While on Leave*

For samples of various forms discussed in this section, refer to Section V. Exhibits, page 50, Leave Without Pay (LWOP)

1. Family Medical Leave Act (FMLA)

2. Disability Leave

3. Military Leave

Employees who go on authorized leaves of absence may continue group insurance coverages for a period of time. The rules differ depending on the kind of leave.

RULES FOR CONTINUING BENEFITS WHILE ON LEAVE

1. Leave Without Pay (LWOP)

While on authorized LWOP, employees may elect to continue Medical, Integrated Behavioral Health Program (IBHP) and Dental, as well as Basic Life and Supplemental Life coverage for a period of time. Eligible employees may also continue State Police Optional Life Coverage.

- For most Leaves Without Pay, continued coverage is available for six months (12 months for authorized employer-sponsored leave for professional and educational purposes).
- To continue coverage, employees must self-pay the total monthly premium for each continued plan, including any portion the State pays for employees in active status. Remember, the IBHP premium is included in the medical plan state share.
- Employees self pay by sending your agency monthly checks or money orders made payable to the Office of Insurance Management. Cash payments are not acceptable.
- Coverage stops when an employee reaches the maximum benefit period or fails to pay the required monthly premiums, whichever comes first.
- After reaching the maximum benefit period, employees may continue Medical, IBHP and Dental for a period of time under COBRA provisions. For more information, see page 41.

2. Family and Medical Leave Act (FMLA)

FMLA is a federal law which entitles most employees to take up to 12 weeks of unpaid leave in a 12 month period for a variety of personal reasons — for example, following birth or adoption of their children, to care for their children, spouses or parents with serious medical conditions, or for their own serious medical conditions. For questions about FMLA, including eligibility, contact the Division of Human Resources or your Deputy Attorney General.

While on FMLA, employees may continue Medical, IBHP, Dental, Basic Life and Supplemental Life. Eligible employees may also continue State Police Optional Life.

- Your agency will continue to pay all employer premiums.
- To continue coverage, employees must pay their share of the monthly premiums.

  Employees who continue to receive paychecks while on FMLA pay their share of the premiums through payroll deductions.

  Employees who are not receiving paychecks while on FMLA must self-pay their share of premiums by sending monthly checks or money orders to you, made payable to the Office of Insurance Management.
- When FMLA ends, employees who continue to be on Leave Without Pay may self-pay Medical, Dental, Basic Life and Supplemental Life premiums for the balance of the six month LWOP period.

3. Disability Leave

Employees who become disabled may continue coverage under various State group insurance plans for a period of time. Following is a brief look at coverage options available to individuals on disability leave. The Office of Insurance Management provides disabled employees with a detailed explanation of these options, including what's available and how long benefits may continue.

A. Medical, Integrated Behavioral Health Program (IBHP) and Dental.
Coverage for the employee and eligible dependents may continue for up to 30 months of disability or until the disability claim closes, whichever occurs first.

- While employees are in active status, employees continue to pay their share of monthly premiums and your agency will pay the employer's share as usual.
- Once employees are on inactive status, the Office of Insurance Management will pay the employer's share of the premiums for the balance of the coverage continuation period. Employees must self-pay their share of premiums by sending a check or money order to you, made payable to the Office of Insurance Management.
- When eligibility for medical, IBHP and dental coverages end, participants may apply for coverage under COBRA provisions. For more information, see page 38.

B. Basic Life. While on an approved disability leave, an employee will continue to be covered by Basic Life. The Office of Insurance Management pays for the coverage, at no cost to the employee or your agency.

C. Supplemental Life. To continue this coverage, an employee must self-pay premiums during the first six months of disability. After that, the insurance company waives the premiums and coverage will continue at no cost to the employee as long as he or she has an open Long Term Disability claim.

4. Military Leave

- For the first six months of military leave, employees may continue coverage for themselves and their eligible family members the same as described for Leave Without Pay. That means they must self-pay the total premiums including employer and employee portions.
- After the six month LWOP period ends, employees may continue medical, IBHP and dental coverage for themselves and dependents under COBRA. Basic Life and Supplemental Life may be converted to individual policies. For more information see page 42.

YOUR ROLE

1. **Submit employee payments.** For employees who are self-paying premiums while on leave...
   - Complete the applicable self-payment reporting forms.
   - Submit white and yellow copies of each form to the Office of Insurance Management, with employee payments attached, by the fifth of each month.
2. **Review reports and adjust premiums**
   - If your agency is on bi-weekly payroll, follow the procedure described in the Employee Information System (EIS) manual.
   - If your agency is on monthly payroll, review the Medical and Dental Billing Statements for the month in which the changes became effective. Cross out any outdated information, write in the new information and recalculate the premium due. For details, see page 10.

FREQUENTLY ASKED QUESTIONS

1. *If employees become ineligible for benefits due to a reduction in work hours, what are their options for continued coverage?*

While these employees are not eligible for the self-pay provisions described for leaves of absence, they may be eligible for continued medical and life insurance coverage as described on page 38.

2. *What happens to coverages when an employee goes on leave with pay?*

Employees on authorized leave with pay maintain their active status as far as State group insurance coverage is concerned. As long as they're on leave with pay, their State group insurance coverage will continue the same as for any other active employee. **Note that if an employee receives reduced pay while on leave, Basic Life Insurance and Disability coverage will be based on the reduced pay.**

3. *Can employees on Leave Without Pay (LWOP) self-pay for continued Disability coverage?*

Employer-paid disability coverage continues for 30 days after the employee goes on leave, after which coverage ends. There's no self-pay option for continuing this coverage.

4. *What happens when an employee on LWOP completes the six month self-pay period?*

After the six month period ends, employees may apply for continued Medical, Dental and IBHP coverage under COBRA. Coverage under the State's Basic Life and Supplemental Life coverage terminates, but individual conversion policies may be available. For more information, see *When A Participant Continues Coverage After Loss of Eligibility*, page 41.

5. *What if an employee on leave self-pays for coverage, but his or her check is returned for non-sufficient funds?*

The Office of Insurance Management will notify you that the check has been returned. To keep coverage in force, the employee will have to send a replacement payment in the form of a cashier's check or money order — personal checks will not be allowed from then on. The notification from the Office of Insurance Management will specify the date by which the employee must make up the shortfall. If the deadline is not met, coverage will be cancelled.

6. *Can employees on authorized leave participate in annual open enrollment?*

Yes, if they're enrolled for coverage during the annual open enrollment period, employees may participate while on leave of absence.

7. When employees go on LWOP, can they elect to continue Medical without Dental or vice versa?

No, employees must elect to continue Medical and Dental coverage—they cannot take one plan without the other.

8. Can employees continue Flexible Spending Account (FSA) participation when they are on Leave Without Pay?

Yes, but participation is available only on an after-tax basis. If any employee is interested in continuing FSA participation while on leave, refer the employee to the Office of Insurance Management for information.

9. When do we start counting the six-month benefit continuation period for LWOP?

The six month period starts effective the first of the month after the date the employee goes on inactive status.

10. Do employees have to complete any special enrollment forms to continue benefit coverage while on FMLA (Family Medical Leave Act)?

While employees do have to complete forms related to their FMLA leave, no special forms are required for group insurance purposes.

11. Say an employee continues medical coverage while on FMLA leave. If this employee goes on LWOP after that, for how long can he or she continue the coverage?

This employee can continue medical coverage for a total of six months, counted from the first of the month following the "qualifying event" for the FMLA leave.

D. WHEN AN EMPLOYEE RETURNS FROM LEAVE

✦ *Resuming Coverage After Leave*

For samples of various forms discussed in this section, refer to Section V. Exhibits, page 50.

1. Medical, Integrated Behavioral Health Plan (IBHP) and Dental
2. Basic Life and Disability
3. Supplemental Life coverage
4. Optional State Police Life
5. Flexible Spending Account (FSA) participation

If employees continued State group insurance coverage while on leave of absence, that coverage will continue when they return to work with no re-enrollment required.

If State group insurance coverage did lapse during the leave, employees have the option to resume participation in any or all available coverage when they return. The rules for resuming coverage differ depending on the kind of leave.

RULES FOR RESUMING COVERAGE AFTER LEAVE

1. Medical, Integrated Behavioral Health Program (IBHP) and Dental

To resume this coverage, returning employees can re-enroll themselves and eligible family members in the same medical plan they had before they left. When they re-enroll for Medical, they automatically re-enroll for IBHP and Dental.

- Coverage is effective the first of the month following the date the new medical plan enrollment form is completed. (or immediately when returning from military leave, provided the new enrollment form is completed within 30 days).
- For employees returning from Leave Without Pay (LWOP), all contract provisions, including new annual deductibles, out-of-pocket limits and waiting periods will apply the same as for new participants.
- For employees returning from military leave, participation will resume at the same status in which they left. This means, for example...
  - ✦ The time an employee was covered before the leave will count toward satisfying medical plan waiting periods for pre-existing conditions.

- ♦ If the employee returns within the same plan year as the leave began, any amounts he or she paid for covered expenses before the leave will still count toward satisfying that year's Medical or Dental plan deductibles or out-of-pocket maximums.

- For employees who previously declined dependent Dental, the declination remains in effect when they return from approved leave.

2. Basic Life

To resume this coverage, returning employees don't have to do anything — if they're eligible, coverage begins automatically the day they return to active status, provided the appropriate premium payments resume.

3. Supplemental Life and Optional State Police Life

To resume this coverage, returning employees must complete a new election form.

- For employees returning from military leave who enroll within 30 days, their coverage begins automatically effective the date they returned. They're not required to provide evidence of good health.
- Employees who return from any other kind of leave, including FMLA leave, must reapply and provide evidence of good health. Their coverage is effective the first day of the month after the insurance company approves the application. The Office of Insurance Management will notify your agency when and if the application has been approved.

4. Flexible Spending Account participation

- Employees who return from leave within the same plan year as when they left will automatically resume participation. Their per paycheck contributions will be withheld at the same level as before the leave.
- Employees who return in a different plan year cannot resume FSA participation. They must wait until the next annual open enrollment period to elect either or both FSAs.

YOUR ROLE

1. **Provide employees with enrollment and other applicable forms.** The Office of Insurance Management provides each agency with a supply of forms. For additional forms, contact us. For samples of various forms discussed in this section, refer to Exhibits, page 50.

2. **Collect, review and file enrollment forms.** To resume lapsed Medical, IBHP and Dental, Supplemental Life, or Optional State Police Life employees must submit new forms to you.

   - Review the submitted forms to be sure they're complete and have been signed by the employee.

- Fill in any information for your agency as required on the forms.
- Across the top of each form, write in “Return from LWOP,” “Return from Disability Leave,” “Return from FMLA,” or “Return from Military Leave” as applicable.
- Make sure late enrollees in the Supplemental Life Insurance or Optional State Police Life plans submit a Statement For Group Benefit Program along with their election forms. The employee completes sections B. C. and D. Your agency completes section A.
- Verify employee eligibility for benefits as outlined on page 7.
- File a copy of all forms in the employee’s personnel file. Submit designated copies of medical election and Dependent Dental Declination forms (if applicable) to the Office of Insurance Management.

3. **Review reports and adjust premiums.** When an employee returns from a break in service, monthly premiums for resumed coverage begins when the coverage goes into effect. If coverage resumes mid-month (for those returning from Military leave), a full month’s premium will be required for that month.
   - If your agency is on bi-weekly payroll, follow the procedure described in the Employee Information System (EIS) manual.
   - If your agency is on monthly payroll, review the Billing Statements for the month in which the changes become effective. Cross out any outdated information, write in the new information and recalculate the premium due. For more details, see page 10.

     NOTE: Keep in mind, FSA contributions are made on the actual pay date.

4. **Collect and submit Work Releases following disability leaves.** Within three days after returning from a disability leave, an employee must provide you with a return to work release completed by his or her physician.
   - Submit the release to the Office of Insurance Management.
   - If the employee has returned under the Disability Program’s rehabilitative provisions, we may contact you for further information about the employee’s work — such as job description, work history or hours worked.

FREQUENTLY ASKED QUESTIONS

1. *When employees return from leave, do they have to fill out new Basic Life Beneficiary Designation Forms?*

No, not unless they want to change their beneficiaries.

2. *If employees previously submitted Dependent Dental Declination forms, do they have to fill out new forms when they return from leave?*

No. The previous declination remains in force, with no new form required.

3. *Do employees returning from leave have to re-enroll for the same coverage they had before?*

Employees don't have to resume any elective coverage unless they want to. However, to make changes to their previous elections, they must follow the rules described in *When An Employee Makes Changes*, page 17. That means, for example...

- Employees cannot switch medical plans or enroll in the Premium Only Plan or Flexible Spending Accounts in mid-year — to make these changes, they must wait for the next annual open enrollment.
- Employees who previously submitted a Dependent Dental Declination cannot enroll their dependents for Dental.

4. *If returning employees were previously enrolled for the Premium Only Plan, do they have to re-enroll to resume participation?*

No, previous elections remain in effect when employees return from leave. That means, for example, if they elected to participate in the plan before the leave, upon their return they will resume paying medical and dental premiums on a before-tax basis through payroll deduction.

E. WHEN AN EMPLOYEE TRANSFERS AGENCIES

✦ *Transferring Benefits*

For samples of various forms discussed in this section, refer to Section V. Exhibits, page 50.

1. Continuing Medical, Integrated Behavioral Health Program, Dental
2. Continuing Premium Only Plan, Flexible Spending Account (FSA), Basic Life and Disability, Supplemental Life
3. Changing benefit elections

This section addresses the rules that apply to benefit coverage when an employee transfers from one state agency to another.

RULES FOR TRANSFERRING BENEFITS

1. Continuing Medical, Integrated Behavioral Health Program (IBHP) and Dental

- To continue coverage from the previous agency, employees must provide the new agency with an updated enrollment form for their current medical plan.
- Employees who previously declined dependent Dental must complete a new Dependent Dental Declination form.

2. Continuing Premium Only Plan, FSA, Basic Life, Supplemental Life

- Your agency is responsible for obtaining applicable paperwork from the previous agency including any enrollment and beneficiary designation forms.

3. Changing benefit elections

- Transferring employees may change current benefit elections only according to the rules described on page18, *When an Employee Makes Changes*.

YOUR ROLE

1. **Provide employees with enrollment and other applicable forms.** The Office of Insurance Management provides each agency with a supply of forms. For additional forms, contact us. For samples of various forms discussed in this section, refer to Exhibits, page 50.

2. Collect, review and submit enrollment forms.

- From employees transferring into your agency, collect new medical enrollment forms for their current plans and, if applicable, new Dependent Dental Declination forms:
  - ♦ Review forms to make sure employees have filled in all required information, including the Transfer section.
  - ♦ File one copy in the employee's personnel file and submit remaining copies to the Office of Insurance Management.
  - ♦ Contact the Office of Insurance Management for instructions if re-enrollment has been neglected.
- Obtain Basic Life and Supplemental Life beneficiary designation forms, Premium Only Plan and FSA enrollment forms from the previous agency. File these in the employee's personnel file at your agency.

3. Review reports and adjust premiums.

As described below, when an employee transfers out of one State agency into another, there's a transition period in which the previous agency pays any applicable premiums on the employee's behalf. Once the transition period is over, the new agency will begin paying employer premiums for that employee. The length of the transition period depends on the date of the transfer.

After the transition period is over, you must adjust premiums for employees who have transferred out of or into your agency — if your agency is on bi-weekly payroll, follow the procedures detailed in the Controller's EIS manual. If your agency is on monthly payroll, update monthly Billing Statements from the Office of Insurance Management by adding or crossing out information and recalculating the premiums.

Transition Periods for Transferring Employees:

- If an employee transfers out of an agency from the 1st through the 14th of a month, that agency will continue to pay applicable employer premiums through the end of that month. Starting the 1st day of the next month, the new agency will begin to pay premiums for the employee's coverage.

  For example, an employee transfers out of an agency on March 14. The previous agency pays the employer portion of premiums through March 31. The new agency pays applicable premiums on the employee's behalf starting April 1.

- If an employee transfers out of an agency from the 15th through the last day of a month, that agency will continue to pay applicable employer premiums through the end of the following month. The new agency will begin to pay premiums as of the first day of the month after that.

  For example, an employee transfers out of an agency on March 15. The previous agency pays the employer portion of premiums through April 30. The new agency pays applicable premiums on the employee's behalf starting May 1.

FREQUENTLY ASKED QUESTIONS

1. ***If a transferred employee declined Supplemental Life at the previous agency, can the employee enroll at the new agency?***

   Not automatically. Eligible employees who previously declined coverage may apply for Supplemental Life at any time. Of course, just like other late enrollees, they will still have to provide evidence of good health.

2. ***If employees declined dependent Dental at their previous agencies, what happens if they don't submit a Dependent Dental Declination form to their new agencies?***

   Delta Dental keeps a copy of each Dependent Dental Declination form on file — and the declination will stay in force. Of course, to decrease any chance of error, it's preferable to have employees submit new forms.

F. WHEN AN EMPLOYEE FILES A CLAIM FOR BENEFITS

✦ *Rules for Filing Claims*

For samples of various forms discussed in this section, please refer to Section V. Exhibits, page 50.

1. Medical, IBHP and Dental Claims

2. Life Insurance Claims

3. Basic Life Accelerated Benefits

4. Short Term Disability claims

5. Flexible Spending Account (FSA) Claims

The rules for filing benefit claims differ from plan to plan. Employees handle their own health care and FSA claims and work directly with the Office of Management when they file disability claims — but your agency provides employment-related information for disabled employees and plays a role in filing life insurance claims on an employee's behalf.

RULES FOR FILING CLAIMS

1. Medical and Dental Claims

- In general, employees simply show their plan identification cards to providers at the time of services. The providers then bill the plans directly.
- When employees are required to file claims, they send their itemized receipts (no claim forms required) directly to the applicable plans.

2. Basic Life, Supplemental Life, State Police Life Insurance Claims

- To file a claim for these benefits, beneficiaries submit a Group Life Claim and Settlement Information form to your agency.
- Along with the form, claimants must include
  - ✦ A certified copy of the death certificate
  - ✦ For Accidental Death claims include a police report or a news clipping about the accident

- Claims should be filed as soon as possible after the event. In any case, the deadline for filing a Life Insurance claim is one year.

3. Basic Life Accelerated Benefits

- To file a claim for these benefits, terminally ill employees file an Accelerated Benefits Claim form directly with the Office of Insurance Management.
- The insurance company determines if the employee is eligible for accelerated benefits and how much the benefit will be.
- We include information about Accelerated Basic Life benefits in our communications to employees filing for short-term disability benefits.

4. Accidental Dismemberment Claims

- To claim Accidental Dismemberment benefits, the employee submits the completed Dismemberment form plus a police report or a news clipping about the accident directly to the Office of Insurance Management.
- Dismemberment claim forms are available from the Office of Insurance Management upon request.

5. Disability Claims

A. Short Term Disability (STD). The Office of Insurance Management manages all disability benefit claims. If a claim is approved, the insurance company pays benefits directly to the disabled employee.

- To apply for benefits, the employee and attending physician must complete and return a disability claim form to the Office of Insurance Management.
- To obtain a claim form, employees or their representatives should contact the Office of Insurance Management directly at:
  - ♦ 208-332-1860 or 1-800-531-0597
  - ♦ email abale@adm.state.id.us
- After the insurance company has reviewed the claim, we'll notify your agency whether the claim as been approved and, if so, the effective date of benefits. The insurance company will send a claims determination letter directly to the employee.

B. Long Term Disability (LTD). If employees are still disabled after Short-Term Disability benefits end, the claim is transitioned from STD to LTD. Consequently, no claim forms are required.

6. Flexible Spending Account (FSA) Claims

- After annual open enrollment, employees who elect to participate in the FSAs receive reimbursement claim forms and filing instructions from the FSA plan administrator.
- Participants file reimbursement claims directly with the plan administrator.

YOUR ROLE

1. **Medical and Dental claims.** If employees' plan ID cards have been lost or damaged, tell employees to email or otherwise contact the Office of Insurance Management. We will ensure new cards are issued immediately.

2. **Life Insurance claims.** Make sure submitted forms are accurate, legible, complete and that the claimant has included any required additional information.

   - Complete the employer's section of the form.
   - Submit the claim to the Office of Insurance Management along with the most recent beneficiary designations and any applicable back-up paperwork.

3. **Disability claims.** The Office of Insurance Management will send you a Statement of Agency form whenever an employee files a Short-Term Disability claim. Your agency must complete and return this form to us. The purpose is to provide us with job-related information about the claimant.

4. **FSA claims.** Refer employees to the Office of Insurance Management for claim forms or filing instructions..

5. **Denial of claims.** If a claim is denied, employees have the right to follow the plan's formal claims appeal process explained in the Employee Group Insurance Handbook. When a claim has been denied, refer the claimant to the Office of Insurance Management for help with the appeal process.

FREQUENTLY ASKED QUESTIONS

1. How do participants file claims for Integrated Health Benefits Program (IBHP) benefits?

Claims do not have to be filed for IBHP benefits, either for covered EAP services or Mental Health and Substance Abuse Treatments expenses. That's because all covered services must be pre-certified by Business Psychology Associates, the IBHP administrator. Approved services are billed directly to the IBHP administrator by the provider.

G. WHEN A PARTICIPANT LOSES ELIGIBILITY

✦ *Losing Eligibility*

For samples of various forms discussed in this section, please refer to Section V. Exhibits, page 50.

1. Why Participants May Lose Eligibility

2. When Coverage Ends

When employees or their dependents lose eligibility for State benefits, their coverage will end. After group coverage ends, participants may be able to continue certain coverages for a period of time — for more information, see Section H. *When A Participant May Continue Coverage After Loss of Eligibility*, page 41.

RULES FOR LOSS OF ELIGIBILITY

1. Why Participants May Lose Eligibility

- Employees lose eligibility when they no longer meet the plans' definition of "eligible employee," as described on page 7. This may happen, for example, because they terminate employment for any reason, including retirement. Or, they may become temporarily ineligible due to a temporary reduction in hours.
- For seasonal or part-time employees whose eligibility is determined on a month by month basis, "termination" means they have formally resigned and would have to be rehired by your agency to return to active status.
- Family members lose eligibility when they no longer meet the plans' definition of "eligible dependents," as discussed on page 7.

2. When Coverage Ends

After eligibility ends, coverage may continue for a period of time depending on the date that eligibility was lost.

- For employees who lose eligibility from the...
  - ✦ 1st through the 14th of a month, coverage for that employee and enrolled family members continues through the end of that month
  - ✦ On or after the 15th of a month, coverage extends through the end of the following month.

- For family members, coverage only continues through the end of the month in which he or she loses eligibility. When a family member no longer qualifies as an eligible dependent for health care benefits, the employee must submit a new medical plan enrollment form. The revised form should include only the names of dependents who are still eligible.

YOUR ROLE

1. **Determine when coverage ends and adjust premiums.** Your agency must determine when an employee's coverage ends due to loss of eligibility. If an employee has dropped an ineligible family member, you will need to adjust the employee's payroll deduction to reflect the new coverage tier, if applicable.

   If your agency is on a bi-weekly payroll system, cessation of premium payments is notice to us that the employee has terminated employment.. If your agency is on a monthly payroll system, draw a line through the employee's name and indicate the date of termination on the monthly Billing Statements. Then recalculate the premium amount owed by your agency.

2. **Process any applicable refunds.** A refund may be due to employees who pay premiums during a period of ineligibility.

   - If an employee is still working for your agency, make refunds through normal payroll channels.
   - If an employee has terminated, submit a written request for a refund to the Office of Insurance Management. The Office of Insurance Management will send the refund directly to the former employee.

FREQUENTLY ASKED QUESTIONS

1. If my agency paid premiums while an employee was ineligible, how do we get a refund for the overpayment?

Overpayments are not refunded to agencies. Instead, you must take a credit through the payroll system. If it's not possible to take a credit, contact the Office of Insurance Management for assistance.

H. WHEN A PARTICIPANT CONTINUES COVERAGE AFTER LOSS OF ELIGIBILITY

✦ *Continuing Coverage*

For samples of various forms discussed in this section, refer to Section V. Exhibits, page 50.

1. Retiree Group Medical

After State benefit coverage ends, employees have options for continuing their coverage, on an individual basis, for a period of time. Eligible retirees may also purchase retiree group medical coverage for themselves and their dependents.

RULES FOR CONTINUING COVERAGE

1. COBRA *(Consolidated Omnibus Budget Reconciliation Act of 1985)*

After eligibility for State group coverage ends, participants may be able to purchase continued Medical, IBHP and Dental coverage for a period of time under COBRA. The Office of Insurance Management administers COBRA and determines participant eligibility to continue health care benefits under COBRA provisions.

Upon request, the Office of Insurance Management mails a detailed information packet to the affected subscriber. This includes a description of how COBRA works, premium rates for continued coverage, and a coverage continuation form.

Participants have 60 days after their group coverage ends to elect COBRA coverage. In general, COBRA coverage is available for up to...

- 18 months when eligibility for group coverage ends due to employee's termination or reduction of hours.
- 36 months for family members who lose eligibility for group coverage due to other reasons, such as divorce or because a child is no longer an eligible dependent as defined by the plan.

Special provisions apply to participants who are receiving Social Security disability benefits.

2. Life Insurance Conversion Policies

After group coverage ends, participants in Basic, Supplemental or State Police Optional Life plans may purchase conversion polices for up to the amount in force at the time of termination. Benefits, provisions and costs of a conversion policy may differ substantially from those available under the State's group plans.

- Evidence of insurability is not required for conversion policies purchased within 31 days after group coverage ends.
- Upon request the Office of Insurance Management sends terminating employees a package of information explaining life insurance conversion options.

3. Retiree Medical

NOTE: The Retiree Medical benefits referred to in this section are presently available to eligible retirees. The plans, benefits, provisions or premium payment arrangements described here may change in respect to current or future retirees.

If eligible, employees who retire from State employment can elect Retiree Medical coverage for themselves and their dependents. (Dental and vision benefits are not available.) The Office of Insurance Management...

- determines eligibility for Retiree Medical benefits,
- handles all Retiree Medical enrollment,
- provides retiring employees with enrollment forms and instructions as well as premium rates and

Currently, eligible retirees may elect coverage under the State's Regence BlueShield of Idaho Module 2 plan. Details of the plan, including provisions and benefits, are included in the retiree group insurance handbook provided to retirees when their initial enrollment form is received, and each plan renewal date thereafter. The retiree handbook is also available on the State website.

To be eligible for medical coverage, retirees must...

- draw a monthly State of Idaho retirement benefit from PERSI, Department of Labor, Judicial Branch retirement system or higher education employees' ORP and
- begin receiving pension plan benefits immediately upon retirement from the State and
- have either an unreduced Regular Retirement Allowance which equals or exceeds the single retiree premium rate in effect on the date of enrollment in the plan or at least 10 years (20,800 hours) of credited state service.

To enroll, retiring employees must submit a Retiree Insurance Benefits Request form to the Office of Insurance Management.

4. Basic Life for Retirees

Eligible retirees from certain State agencies continue to be covered by Basic Life after they leave work. This benefit is available only to retirees of these agencies...

- Judges and Justices
- Department of Labor
- University of Idaho, Idaho State University, Boise State University, Lewis-Clark State College and Eastern Idaho Technical College.

The individual agencies make the eligibility regulations, apprise employees who qualify, and pay the premiums. Basic Life coverage for retirees can vary based on age and position.

YOUR ROLE

1. **COBRA, Life Insurance Conversion Policies and Retiree Medical,** refer employees to the Office of Insurance Management for information and application forms.
2. **Retiree Basic Life,** if applicable to your agency, refer to your procedure manual for adjusting premiums and updating reporting forms.

FREQUENTLY ASKED QUESTIONS

1. Is the Regence BlueShield of Idaho Plan, Module 2 exactly the same for retirees as for active employees?

The medical and prescription drug benefits are the same except the retiree version...

- does not include vision care benefits and
- mental health and substance abuse treatment benefits are provided through the Blue Shield Plan, not the Integrated Health Benefits Program (IBHP).

IV. SUMMARY OF FREQUENTLY ASKED QUESTIONS

WHEN AN EMPLOYEE IS NEW

1. What happens if a new employee fails to submit any enrollment forms?

That employee is assumed to have declined all elective coverage.

2. Do we have to do anything special to enroll employees and dependents for Dental or the Integrated Behavioral Health Program (IBHP)?

No, simply send in the designated copies of the completed medical plan forms to the Office of Insurance Management. We'll forward the forms to all the insurers, including the elected medical plan, Delta Dental and Business Psychology Associates, the IBHP insurer.

3. If employees have declined medical for themselves or dependents, how are they enrolled for Employee Assistance Program (EAP) services?

EAP services are available to all benefit-eligible employees and dependents, no enrollment necessary. When a participant first calls Business Psychology Associates to pre-approve EAP services, the Office of Insurance Management is contacted to verify eligibility.

4. Do we have to verify dependent eligibility for benefits?

While agencies are required to verify employee's eligibility, you are not required to verify dependents' eligibility for enrollment.

5. If an employee submits a Dependent Dental Declination form, but later acquires a new dependent, is the new dependent eligible for dental coverage?

Once an employee declines dependent dental, coverage is declined for all dependents present and future. This new dependent may only be enrolled for dental when and if the State holds a special Dental open enrollment.

6. If an employee enrolls for Medical but doesn't enroll his or her children for coverage, does that mean the employee has also elected to decline dependent Dental?

In the case of this employee, if he or she later enrolls dependents for Medical they're still eligible for Dental coverage. Only an employee who enrolls dependents for medical coverage but submits a Dependent Dental Declination form is considered to have declined dependent dental.

7. For employees who participate in the Premium Only Plan, how do I make sure their premiums are deducted before-tax?

If your agency is on a bi-weekly payroll, enter the pre- and post-tax deduction codes provided in the Controller's Office EIS manual. If your agency is on monthly payroll, take the appropriate action specified by your payroll deduction process.

8. How are new employees enrolled for Basic Life and Disability Insurance, since there are no enrollment forms?

Enrollment happens automatically but premium deductions do not. If your agency is on biweekly payroll, you must submit the appropriate payroll deduction setup form(s) to the Controller's Office. For agencies on monthly payroll, you must revise your agency's Basic Life Premium Reconciliation form.

9. Following initial enrollment, is there a deadline for sending the new election forms to the Office of Insurance Management?

While there's no official deadline, agencies should submit the applicable forms as promptly as possible to be sure that coverage begins on schedule.

10. Why would an employee submit a Beneficiary Designation With UTMA (Uniform Transfer to Minors Act) Custodian form instead of just a Beneficiary Designation form?

The Beneficiary Designations with UTMA Custodian form applies only to those who designate minors as their beneficiaries.

WHEN AN EMPLOYEE MAKES CHANGES

1) During open enrollment, do employees have to return new enrollment forms if they want to continue benefit elections "as is" for the coming plan year?

That depends on the plan:

- For the FSAs, employees must submit new election forms to participate each year.
- For the Premium Only Plan, no new forms are required.
- For the Medical plans, new enrollment forms are required only if employees are switching to a new plan.

2) Do employees have to complete a new election form to switch from one Regence BlueShield of Idaho module to another during annual open enrollment?

Yes. To switch to a different module, an employee must complete a Regence BlueShield of Idaho Medical Plan Enrollment form on which he or she indicates the new plan.

3) If employees are enrolled in the HMOBlue Point of Service (POS) medical plan, can they switch to another plan if their covered dependents move out of the POS service area?

No, employees may only switch plans during annual open enrollment or if they move out of the plan service area. However, the POS plan has special coverage provisions for enrolled children who move away, for example, due to divorce or because they're going to school. For more information, refer the employee to his/her HMOBlue Member Handbook or the Employee Group Insurance Handbook.

4) How are newly acquired dependents enrolled for Dependent Life?

There's no special procedure to enroll dependents for this coverage. If the employee ever makes a claim for dependent benefits, then we will verify that the dependent was eligible.

WHEN AN EMPLOYEE GOES ON LEAVE

1. If employees become ineligible for benefits due to a reduction in work hours, what are their options for continued coverage?

While these employees are not eligible for the self-pay provisions described for leaves of absence, they may be eligible for continued medical and life insurance coverage as described on page 38.

2. What happens to coverages when an employee goes on leave with pay?

Employees on authorized leave with pay maintain their active status as far as State group insurance coverage is concerned. As long as they're on leave with pay, their State group insurance coverage will continue the same as for any other active employee. **Note that if an employee receives reduced pay while on leave, Basic Life Insurance and Disability coverage will be based on the reduced pay.**

3. Can employees on Leave Without Pay (LWOP) self-pay for continued Disability coverage?

Employer-paid disability coverage continues for 30 days after the employee goes on leave, after which coverage ends. There's no self-pay option for continuing this coverage.

4. What happens when an employee on LWOP completes the six month self-pay period?

After the six month period ends, employees may apply for continued Medical, Dental and IBHP coverage under COBRA. Coverage under the State's Basic Life and Supplemental Life coverage terminates, but individual conversion policies may be available. For more information, see *When A Participant Continues Coverage After Loss of Eligibility*, page 41.

5. What if an employee on leave self-pays for coverage, but his or her check is returned for non-sufficient funds?

The Office of Insurance Management will notify you that the check has been returned. To keep coverage in force, the employee will have to send a replacement payment in the form of a cashier's check or money order — personal checks will not be allowed from then on. The notification from the Office of Insurance Management will specify the date by which the employee must make up the shortfall. If the deadline is not met, coverage will be cancelled.

6. Can employees on authorized leave participate in annual open enrollment?

Yes, if they're enrolled for coverage during the annual open enrollment period, employees may participate while on leave of absence.

7. When employees go on LWOP, can they elect to continue Medical without Dental or vice versa?

No, employees must elect to continue Medical and Dental coverage — they cannot take one plan without the other.

8. Can employees continue Flexible Spending Account (FSA) participation when they are on Leave Without Pay?

Yes, but participation is available only on an after-tax basis. If any employee is interested in continuing FSA participation while on leave, refer the employee to the Office of Insurance Management for information.

9. When do we start counting the six-month benefit continuation period for LWOP?

The six month period starts effective the first of the month after the date the employee goes on inactive status.

10. Do employees have to complete any special enrollment forms to continue benefit coverage while on FMLA (Family Medical Leave Act)?

While employees do have to complete forms related to their FMLA leave, no special forms are required for group insurance purposes.

11. Say an employee continues medical coverage while on FMLA leave. If this employee goes on LWOP after that, for how long can he or she continue the coverage?

This employee can continue medical coverage for a total of six months, counted from the first of the month following the "qualifying event" for the FMLA leave.

WHEN AN EMPLOYEE RETURNS FROM LEAVE

1. *When employees return from leave, do they have to fill out new Basic Life Beneficiary Designation Forms?*

No, not unless they want to change their beneficiaries.

2. *If employees previously submitted Dependent Dental Declination forms, do they have to fill out new forms when they return from leave?*

No. The previous declination remains in force, with no new form required.

3. *Do employees returning from leave have to re-enroll for the same coverage they had before?*

Employees don't have to resume any elective coverage unless they want to. However, to make changes to their previous elections, they must follow the rules described in *When An Employee Makes Changes*, page 18. That means, for example...

- Employees cannot switch medical plans or enroll in the Premium Only Plan or Flexible Spending Accounts in mid-year — to make these changes, they must wait for the next annual open enrollment.
- Employees who previously submitted a Dependent Dental Declination cannot enroll their dependents for Dental.

4. *If returning employees were previously enrolled for the Premium Only Plan, do they have to re-enroll to resume participation?*

No, previous elections remain in effect when employees return from leave. That means, for example, if they elected to participate in the plan before the leave, upon their return they will resume paying medical and dental premiums on a before-tax basis through payroll deduction.

WHEN AN EMPLOYEE TRANSFERS INTO AN AGENCY

1. *If a transferred employee declined Supplemental Life at the previous agency, can the employee enroll at the new agency?*

Not automatically. Eligible employees who previously declined coverage may apply for Supplemental Life at any time. Of course, just like other late enrollees, they will still have to provide evidence of good health.

2. *If employees declined dependent Dental at their previous agencies, what happens if they don't submit a Dependent Dental Declination form to their new agencies?*

Delta Dental keeps a copy of each Dependent Dental Declination form on file — and the declination will stay in force. Of course, to decrease any chance of error, it's preferable to have employees submit new forms.

WHEN AN EMPLOYEE FILES A CLAIM FOR BENEFITS

1. *How do participants file claims for Integrated Health Benefits Program (IBHP) benefits?*

Claims do not have to be filed for IBHP benefits, either for covered EAP services or Mental Health and Substance Abuse Treatments expenses. That's because all covered services must be pre-certified by Business Psychology Associates, the IBHP administrator. Approved services are billed directly to the IBHP administrator by the provider.

WHEN A PARTICIPANT LOSES ELIGIBILITY

1. *If my agency paid premiums while an employee was ineligible, how do we get a refund for the overpayment?*

Overpayments are not refunded to agencies. Instead, you must take a credit through the payroll system. If it's not possible to take a credit, contact the Office of Insurance Management for assistance.

WHEN A PARTICIPANT CONTINUES COVERAGE AFTER LOSS OF ELIGIBILITY

1. *Is the Regence BlueShield of Idaho Plan, Module 2 exactly the same for retirees as for active employees?*

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- does not include vision care benefits and
- mental health and substance abuse treatment benefits are provided through the Blue Shield Plan, not the Integrated Health Benefits Program (IBHP).

V. EXHIBITS

ENROLLMENT FORMS

Premium Only Plan Election form

Medical Enrollment forms:

- *Regence BlueShield of Idaho Plans (Module 1 or Module 2)*
- *HMOBlue Point of Service Plan*

Dependent Dental Declination form

Basic Life Beneficiary forms:

- *Beneficiary Designation form, GP 39859-3*
- *Beneficiary Designation With UTMA Custodian form, GP 34795-1*

Supplemental Life Beneficiary Designation form, GP 39859-3

Health Statement for Group Benefit Program form, GP 34847

State Police Life Election Form, GP 41677

Flexible Spending Account Election form

Retiree Insurance Benefits Request form

CLAIM FORMS

Group Life Claim and Settlement Information form, GP 40010

Dismemberment form, GP 1155-14

Accelerated Benefit Claim form, GP 32248-2

Statement of Agency form

ADMINISTRATIVE FORMS

Self-Pay Reporting form

Monthly Payroll Billing Statement and Basic Life Premium Reconciliation